TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Idris Gharbaoui

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-15-4077-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Codes 13132/59 and 13133/59 were documented in the Operative Report as it clearly documents the complex repair of Middle & Ring fingers as patient had a large and complex lacerations all the way down to the bone with exposure of the flexor tendon sheath done with Repair of the Nail bed (11760x2) on Middle and Ring finger."

Amount in Dispute: $907.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding this bill and date of service, the appending of the modifier 59 is not supported..."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2015	13132 -59, 13133 -59	$907.12	$588.73

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed
   - X901 – Documentation does not support level of service billed
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code X901 – "Documentation does not support level of service billed." 28 Texas Administrative Code §134.203 (b) states

> For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
>
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the submitted claim finds the disputed codes are;

- 13132 – Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet 2.6 cm to 7.5cm
- 13133 - Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)
- Both included the 59 modifier or "Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

Review of the "operative report" finds that;

- "complex wounds involving the right index, middle, and ring fingers"
- "A small arciform incision was placed on the volar, and radial aspect of the thumb MCP joint. A full thickness flap was elevated, approximately 2 cm in length x 1 cm in width."
- "Repair of the 3 nail beds was also performed."

The carrier states in their position statement, "The billed CPT of 13132 flags a NCCI Edit when billed with CPT 11760 and CPT 15574. Per CMS guidelines above, the Modifier 59 is not supported as the complex repairs were performed on the same fingers (right index, ring and middle) during the same surgical session as the nailbed repair (CPT 11760) and the pedical formation(15574)."

While only surgery was performed, the documentation states that the thumb was the site of the "direct tube pedicle" and the repairs were to the index, ring and middle fingers. Thus, supporting separate incision/excision. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative code 134.203 (c) states in pertinent part,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The services in dispute will be calculated as follows;

   - Procedure code 13132, service date February 3, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 4.78 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 4.87082. The practice expense (PE) RVU of 3.56 multiplied by the PE GPCI of 1.006 is 3.58136. The malpractice RVU of 0.66 multiplied by the malpractice GPCI of 0.955 is 0.6303. The sum of 9.08248 is multiplied by the Division conversion factor of $70.54 for a MAR of $640.68. The CMS multiple procedure reduction guidelines or 50% reduction in the allowable applies to this code. Therefore, the MAR is $320.34.
   - Procedure code 13133, service date February 3, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.19 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 2.23161. The practice expense (PE) RVU of 1.26 multiplied by the PE GPCI of 1.006 is 1.26756. The malpractice RVU of 0.32 multiplied by the malpractice GPCI of 0.955 is 0.3056. The sum of 3.80477 is multiplied by the Division conversion factor of $70.54 for a MAR of $268.39.

3. The total allowable reimbursement for the services in dispute is $588.73. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $588.73. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $588.73.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $588.73 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.